VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

July 21, 2016

Ms. Brenda Egbert, Manager
Bradford Oasis
92 Cottage Street
Bradford, VT 05033-8897

Dear Ms. Egbert:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on May 9, 2016. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0618	A. BUILDING: _____ B. WING _____	C 05/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD OASIS	92 COTTAGE STREET BRADFORD, VT 05033

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R100	Initial Comments: An unannounced on-site complaint investigation and re-licensure survey were conducted by the Division of Licensing and Protection on 05/09/2016. The following state regulatory violations were identified:.	R100		
R104 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.1 Admission 5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other applicable financial issues, including an explanation of the home's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI or ACCS benefits. This admission agreement shall specify at least how the following services will be provided, and what additional charges there will be, if any: all personal care services; nursing services; medication management; laundry; transportation; toiletries; and any additional services provided under ACCS or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the home's personal needs allowance policy. (1) In addition to general resident agreement requirements, agreements for all ACCS participants shall include: the	R104	See attached	

Brenda Egbert, mgr 5/27/2016

R104 - R224 POC's accepted 7/18/16 PMotaRN

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R104	Continued From page 1 ACCS services, the specific room and board rate, the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment. This REQUIREMENT is not met as evidenced by: Based upon 1 of 3 records reviewed and confirmed by interview with the manager, the admission contract that reflects the monthly rate to be charged was not found. (Resident #3) Findings include: 1. Resident #3 was admitted in May 2015 and a signed admission agreement that describes the charges for Assisted Community Care Services (ACCS) rate, other services covered and applicable financial issues was not found. In addition, the resident's financial situation had changed with a rate change increase as noted per the 'receipt received' documentation. However, no amended contract was found. Per interview on 05/09/16 at 11:10 AM the Manger confirmed the required documentation was not in the resident's chart nor found elsewhere.	R104	See attached	
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition.	R136	See attached	

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R136	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the community care home failed to assess 1 of 4 residents (#1) upon return from a 4-day stay at a hospital. The specifics are as follows: Per medical record review on 05/09/2016, Resident #1 was admitted to the community care home on 5/16/2015 with dementia, gastric bleeding, cardiac arrhythmias requiring a pacemaker and Chronic Obstructive Pulmonary Disease. S/he was admitted to the hospital with a change in respiratory status on March 26, 2016 and returned to the community care home on March 30, 2016. The last assessment was documented as having been done on 3/16/2016 and did not reflect the latest hospitalization, nor the change in status for Resident # 1, who returned with a diagnosis of congestive heart failure. No new assessment was completed when Resident # 1 was readmitted to the community care home, to indicate this change in status and how it impacted the care needs. On 5/6/2016 s/he was admitted to hospice services. There is no evidence in the medical record to support or give reason why Hospice was needed. This is confirmed by the manager during interview at 3:45 PM,	R136	see attached	
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services	R145	see attached	

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R145	Continued From page 3 necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the community care home failed to oversee development of a written plan of care that is based on the abilities and needs for 4 of 4 residents in the sample (#1, 2, 3 and 4), as identified in their resident assessments. The specifics are as follows: 1. Resident #4 was admitted October 2015, in which the initial assessment identified behaviors and mood as anxious, impatient, verbally and physically abusive as well as socially inappropriate and resists care. There are no specific, clear interventions to support the staff and resident with aggressive and abusive behaviors in the care plan. The care plan/problem list notes the resident's program of psychiatry, counseling, community integration with the Clara Martin Center. It directs staff to maintain a routine, help keep appointments and be alert for signs of decompensation, erratic behaviors. Per interview at 3:00 PM the Manger stated that the resident's behaviors started about a month after being admitted and 'started to ramp-up'. The House Manager stated that there has been some conversations with the sister and Clara Martin Center's Case Manager about the behaviors. The Manager acknowledged that there is no documentation as to what steps should be taken. The Manger confirmed that a care plan has not been developed with specific interventions or goals for the abusive behaviors. 2. Resident #3's care plan does not describe the care and services to assist and maintain the	R145	see attached	

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R145	Continued From page 4 resident's well-being. The care plan states vague directives as "reduce stressful situation, offer support...medications and mental health support, evaluate mood and reduce/eliminate stressors as possible". When asked what specific care and services will help the resident the Manager at that acknowledged that the stressors were not identified. The Manager at 3:10 PM confirmed the care plan was not individualized to describe the care and services to assist and maintain the resident's well-being. 3. Resident # 1 does not have a care plan that is reflective of his/her current status and the one in the medical record was not updated with changes since a hospitalization in March 2016. The current care plan further does not indicate the additional care needed by the resident, nor that Hospice was begun on 5/6/2016. This is confirmed during interview with the manager at 3:25 PM. 4. Resident # 2 was admitted to the community care home on 1/24/2015 with Diabetes, obesity, venous stasis, kidney disease and atrial fibrillation. The care plan in the medical record is dated 8/31/2015 and there is no evidence to indicate that there was an original care plan completed within 7 days of admission. Resident # 2 has 'circ aides' to his/her legs and is apply to apply them unassisted by staff. That the care plan does not reflect this and that an original care plan was not done are both confirmed by the manager during interview at 3:50 PM.	R145	see attached	
R151 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (8)	R151	see attached	

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R151	Continued From page 5 Ensure that the resident's record documents any changes in a resident's condition; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the community care home failed to ensure that the resident's record documents any changes in the condition of 1 of 4 residents, (Resident # 1). The specifics are listed below: Per medical record review on 05/09/2016, Resident #1 was admitted to the community care home on 5/16/2015 with dementia, gastric bleeding, cardiac arrhythmias requiring a pacemaker and Chronic Obstructive Pulmonary Disease. S/he was admitted to the hospital with a change in respiratory status on March 26, 2016 and returned to the community care home on March 30, 2016. The last assessment was documented as having been done on 3/16/2016 and did not reflect the latest hospitalization, nor the change in status for Resident # 1, who returned with a diagnosis of congestive heart failure. There was no new assessment completed when Resident # 1 was readmitted to the community care home to indicate this change in status and how it impacted the care needs. On 5/6/2016 s/he was admitted to hospice services. There is no evidence in the medical record to support or give reason why Hospice was needed. This is confirmed by the manager during interview at 3:45 PM.	R151	See attached	
R155 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c. (12)	R155	See attached	

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R155	Continued From page 6 Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies. This REQUIREMENT is not met as evidenced by: Based on record review and interview the nurse failed to assume responsibility for staffs' performance in the administration with resident medications for 1 of 4 applicable residents in survey (Resident #3). Findings include the following: 1. Per review of the MAR [medication administration record] it was documented that Resident #3 had received a controlled drug without an order, and as needed [PRN] medications were given without documenting the effectiveness. Resident #3 had a physician order dated 01/14/16 to discontinue Ambien [for sleep]. Per review of the MAR and/or controlled substance count sheet, Ambien was administered on 01/30/16 and 01/31/16 and on 03/13/16 and 03/14/16. The resident also had orders and received Sumatripan 50mg PRN [for headaches], Buspar [an anti-anxiety], as well as Tylenol with codeine [for pain], but evidence demonstrates that staff did not consistently record on the MAR [medication administration record] whether the medications had the desired effects. Review of policy and procedure shows staff are to give medications only as ordered and to document whether the PRN medications had the desired effects. The Manager/Nurse acknowledged during interview at 11:10 AM that audits are not done on the charts nor the controlled substance count sheet. S/he confirmed responsibility for staff performance.	R155	See attached	

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R155	Continued From page 7 Also see R-171.	R155		
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to assure that all resident medications administered by staff had a current physician's written order in the medical record for 1 of 4 applicable residents in the sample (Resident #3) 1. Per record review, Resident #3, who was admitted in May 2015, had no written physician orders in the medical record for the anti-anxiety medication Buspar. The resident had received this medication, according to the MAR (Medications Administration Record) from September 2015 until March 2016. The Manager/RN stated "I remember the phone call, talking to the doctor at that time" but confirmed there is no written signed order in the resident's chart.	R162	see attached	
R171 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management	R171	see attached	

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R171	Continued From page 8 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the community care home failed to provide documentation for residents receiving psychoactive medications that side effects are being monitored, failed to ensure all as needed [PRN] medications administered included the date, time, reason for giving the medication, and failed to ensure medications were administered as ordered for 2 of 4 residents (# 1 and # 3). The home also failed to have a current list of those individuals who are administering medications to residents, including those to whom a nurse has delegated administration. The specifics are as follows:	R171	see attached	

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R171	Continued From page 9 1. Resident #3 has a diagnosis of major depression, general anxiety and mood disorder in which psychoactive medications were given without monitoring for side effects, PRN medications were given without documenting the effects and medications were given without physician's orders. The resident received scheduled antipsychotic medication, Seroquel, that had no documentation showing that the facility was monitoring for side effects. In addition, from admission in May 2015 until present, the PRN medications Sumatripan 50 mg PRN for headaches, Buspar for anti-anxiety, as well as Tylenol with codeine for pain, were not consistently recorded on the MAR [medication administration record] whether the medications had the desired effects. Furthermore, a physician order dated 01/14/16 noted a change to an order to discontinue Ambien [for sleep] and to give Trazodone 50 mg. Per review of the MAR and/or controlled substance count sheet, Ambien was administered on 01/30/16 and 01/31/16 and on 03/13/16 and 03/14/16. 2. Per medical record review Resident # 1 had been receiving Seroquel daily. This medication was recently changed to Risperdal daily. There had been no assessment of nor monitoring of possible side effects, for either medication. 3. Per observation, the med delegation list in the front of the MAR contains names of individuals who no longer work at the home and does not have names of some newer employees who are able to administer medications. The Manager during interview at 11:10 AM confirmed that there was no documentation for the monitoring of side effects of psychoactive medication for both of the examples above, that	R171	see attached	

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R171	Continued From page 10 staff were not consistently monitoring for PRN medication desired effects, that discontinued medication was administered and that the medication delegation list was not current or accurate. Also see R-155. This is a repeat citation.	R171	see attached	
R173 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced by: Based on observations and staff confirmations, the community care home failed to assure that resident medications that the home manages are stored in locked compartments. The specifics are as follows: Per observation during the initial tour at 9:40 AM, the medication cart has a bubble pack, containing 1 synthroid pill, 2 Vitamin B tablets and 1 omeprazole tablet placed between the pages of the Medication Administration Record (MAR), on top of the locked medication cart. This is confirmed by the manager by her observation at	R173	see attached	

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R173	Continued From page 11 10:20 AM. Surveyors further observed upon leaving the community care home at 5:45 PM that the medication cart was not locked. It is kept in the entry way to the home. This is confirmed by the manager at 5:45 PM.	R173		
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on review of staff personnel files and staff	R179	See attached	

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R179	Continued From page 12 interviews, the community care home failed to assure that staff providing direct care to residents completed 12 hours of required training. The specifics are as follows: During record review on 05/09/16, 5 of 5 direct care staff's in-service records lacked documentation of at least 12 hours of annual training which included the mandatory elements of Resident Rights, Respectful Effective Communication, Infection Control, First Aid response, and Policies and procedures regarding mandatory reports. In addition, three new staff did not receive the specialized training prior to providing direct care to residents. The House Manager at 2:00 PM confirmed the above findings.	R179		
R188 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any.	R188	see attached	

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R188	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that 1 of 4 resident records included all of the required information. (Resident #3) Findings include: 1. Per record review, there were no signed admission agreements, no evidence for instruction in case of death, next of Kin or a copy of the document giving legal authority to another for Resident #3. Resident #3 was admitted in May 2015, however, there is no signed admission agreement. Furthermore, during interview at 11:10 AM, the Manger stated that the father had authority as the payee, however no documentation was evident in the chart nor was any kin identified in case of death. This was confirmed by the Manager at that time. Also see R-104. This is a repeat citation.	R188		
R189 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care.	R189	see attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0618	A. BUILDING: _____ B. WING _____	C 05/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD DASIS	92 COTTAGE STREET BRADFORD, VT 05033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R189	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the record for 1 applicable resident in the targeted sample did not include signed telephone orders. (Resident #3) Findings include: 1. Per record review, Resident #3, who was admitted in May 2015, had no written physician orders in the medical record for the anti-anxiety medication, Buspar. The resident had received this medication, according to the MAR (Medications Administration Record) from September 2015 until March 2016. The Manager/RN stated "I remember the phone call, talking to the doctor at that time" but confirmed there is no written signed order in the resident's chart. Also see R-162.	R189		
R190 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on review of the community care home's personnel records and staff interview, the home failed to obtain the required background checks for 1 of 5 staff reviewed. The specifics are as follows: Per review of personnel files, 1 employee hired on 5/6/2016 did not have any of the background	R190	see attached	

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R190	Continued From page 15 checks (Child and Adult Abuse registry or VCIC (VT Criminal data base)) returned prior to beginning work/orientation on 5/9/2016. This is confirmed by the manager during interview at 4:00 PM.	R190		
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the home did not report to the Division of Licensing and Protection (DLP) a pattern of resident to resident incidents in a timely manner in for 1 of 4 applicable records reviewed, nor did the home develop a plan to deal with the behaviors. (Residents #4) Findings include: Per record review, a pattern of aggressive behaviors involving Resident #4, was not reported as required nor was a plan developed to deal with the behaviors. During interview one resident who wishes to remain anonymous stated that [the house pet, a dog] "didn't like (Resident#4) who has kicked him and is mean". Resident #4 was	R208	see attached	

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admitted in October 2015, in which the initial assessment identified behaviors and mood as anxious, impatient, verbally and physically abusive as well as socially inappropriate and resists care. The aggressive behaviors occurred, per the staff log book,as follows: 12/10/15 ..."nearly started a fist fight at breakfast today"; 01/26/16...picked a fight with another resident; 02/10/16 ..."other residents are pretty irritated by [resident's] behaviors, disrupts meals"; 02/20/16 ..."threatened [male resident] and shoved [female resident]; 02/21/16...5:30 PM, threw a chair into the hallway- [resident#4] was behind [female resident] and asked her to sit somewhere else..concerned about safety"; 03/26/16 ..."threw a chair towards the bathroom, a resident standing near the bathroom was not in danger"; 04/11/16 & 04/12/16 "[Resident #4] verbally abusive".

Per interview at 3:00 PM the Manager stated that the resident's behaviors started about a month after being admitted and started to ramp-up. The House Manager stated that there has been some conversations with the sister and Clara Martin Center's Case Manager about the behaviors. The manager acknowledged that this resident had kicked the house pet (dog) in front of other

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R224	Continued From page 17 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, all residents of the home were not free from mental, verbal or physical abuse. Findings include: During interview one resident who wishes to remain anonymous stated that [the house pet, a dog] "didn't like (Resident#4) who has kicked him and is mean". Resident #4 was admitted in October 2015, in which the initial assessment identified behaviors and mood as anxious, impatient, verbally and physically abusive as well as socially inappropriate and resists care. The aggressive behaviors occurred, per the staff log book,as follows: 12/10/15 ..."nearly started a fist fight at breakfast today"; 01/26/16...picked a fight with another resident; 02/10/16 ..."other residents are pretty irritated by [resident's] behaviors, disrupts meals"; 02/20/16 ..."threatened [male resident] and shoved [female resident]; 02/21/16...5:30 PM, threw a chair into the hallway- [resident#4] was behind [female resident] and asked her to sit somewhere else..concerned about safety"; 03/26/16 ..."threw a chair towards the bathroom, a resident standing near the bathroom was not in danger"; 04/11/16 & 04/12/16 "[Resident #4] verbally abusive". Per interview at 3:00 PM the Manager confirmed that Resident #4 had kicked the house pet (dog) in front of other resident, which could be upsetting, threatening/aggressive behaviors	R224	see attached	

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R224	Continued From page 18 towards other resident, and did put [his/her] hands on another resident's shoulder. Also see R-208.	R224	see attached Brenda Egbert, mgr 5/27/2016	

BRADFORD OASIS
PLAN OF CORRECTION
MAY 2016

RESIDENT CARE AND HOME SERVICES
R104 ADMISSION
Correct. Peter Lawlor's closed record does not have the admission agreements. I know they exist since I made copies for him just the week before. I assume they have been misfiled and I have not looked for them. All other open and closed records do have signed admission agreements and the residents or their representatives also have copies. Maintaining up to date admission agreements is and will continue to be Bradford Oasis policy.

R136 ASSESSMENT
All Bradford Oasis residents do have admission and annual assessments completed. K Pollender did not have a new assessment completed after the 4 day hospital stay. The problem list/plan of care had not been updated to include hospice care, but the nurse's notes contain references to Kitty's decline, conversation with her MPOA, and PCP that hospice is appropriate at this time. The hospice plan of care and ERC/Hospice admission are in her chart. In the future, Bradford Oasis will be more complete in documenting changes in condition.

R145 CARE PLAN
All residents have a care plan based on the resident assessment. The problem list/care plans are not in the detail required by inspectors. All care plans are in the process of being reviewed and updated where necessary. Bradford Oasis will maintain more detailed problem list/care plans in the future.

R151 CARE PLAN
The care plans are not in the detail requested. As above, all care plans are being updated to individual needs. #3 did not reflect well in the care plan although there is general instruction on his behavior and activities he can use to calm himself. This is located in his resident profile and his file in the med book. Bradford Oasis will maintain more detailed problem list/care plans in the future.

R155 MEDICATION MANAGEMENT
Proper documentation of prn effect has not been done well lately. We recently had a new documentation inservice on daily notes and medications. Prn documentation has become part of the shift report and narcotic count. This practice will improve compliance with documenting prn effect. Med sheet documentation will be reviewed more often by Bradford Oasis management and employees counseled on lapses. #3 had controlled drugs administered after d/c order. The order had been clearly d/c'd on the MAR but had not been yellowed out across the page. All d/c'd meds will now be yellowed out across the entire page to avoid future incidents. This has also been addressed in a med inservice and control sheets will now be monitored by RN, manager.

R162 MEDICATION MANAGEMENT
#3 did not have the written order in his chart. I know that the order was present and remember the conversation with MD about its dosing order. Unfortunately it is not present in the resident's closed record. I have nothing I can say to this situation. I have a practice of not giving medications until I have a written order. It has been difficult in the past to get written orders in time, so I don't accept them. Written orders are the only way meds can be delivered from our pharmacy and I have seldom received verbal orders.

R171 MEDICATION MANAGEMENT
Documentation of refused meds and effect of prn meds has been an issue for us from time to time. This has been addressed in the recent documentation inservice and is now part of the shift change sign off. All scheduled and prn meds will be fully documented before the oncoming shift can accept responsibility and keys. The authorized staff list for medication administration does have old employees on it. The indicated a willingness to be per diem staff. There are staff still in orientation who have not yet been added to the list. The list is now updated. I did not realize that residents on psychoactive meds needed to be assessed for side effects. There is now a policy in place and nursing notes now include this assessment. Meds left out on the cart and an unlocked cart are occasional errors. This has been addressed in the med inservice.

R179 STAFF SERVICES
Several of the required inservices were informal and conducted during staff meetings. I am in the process of creating more formal outlines for the topics not covered by existing education modules. Staff are strongly encouraged to keep up individual lessons. It will be a focus in the near future as new staff are well in place. We are having frequent inservices to catch up on the slow start this year.

R188 RESIDENT CARE AND HOME SREVICES
Resident #3 does have incomplete info on the front sheet. He has no death/funeral plans, his father is not designated as next of kin, his father may have completed the payee approval before resident's discharge, but we did not get documentation. Not all residents have death/funeral plans and we will now highlight this information rather than leave it off the front sheet.

R189 RESIDENT CARE AND HOME SERVICES
As stated before, the written order for Buspar is not in the record although I know it was obtained. I will keep better order of discharged charts when they are compiled.

R190 RESIDENT CARE AND HOME SERVICES
Yes. One new employee began orientation and job shadow before the background check had been received. I will not allow this to happen in the future. I further understand these can now be obtained online and I will learn the process.

R208 RESIDENT CARE HOME AND SERVICES

We do have a resident who has created distress, turmoil, and potential violence in the home. We were expecting some behavioral issues and have a list of calming practices he uses. I was also in contact with his guardian and mental health case manager concerning events as they happened. We expected that issues would be occasional and fairly easily managed. This was not so much the case. At no time did his case manager assure us the emergency line would be helpful, that APS would be appropriate, or that we should call the police. We know realize how to best use our options. Although his behavior has improved over the last few months we are well prepared to counter any further outbursts with legal action. The team plan is to find him a new residence and I cannot recommend level III residential care for him. I am exploring other possibilities and his behavior or similar behavior of future residents will not be tolerated.

R224 RESIDENTS RIGHTS

I will no longer tolerate distressing, disturbing, or possibly violent behavior from any resident. Any resident will be told it will not be tolerated and a next event will result in legal action – APS, police, and certainly. I will add this to our household policies as emphasis on admission.

Front sheets are reviewed
RA, problem list/care plan updated
Inservice outlines in process
Staff and med admin lists updated

I believe all deficiencies are corrected or in the process. This should be completed by June 15.

May 27, 2016

Brenda Egbert, mgr